Connecticut Healthcare Innovation Plan

State Innovation Model Initiative

STATE OF CONNECTICUT

Presentation to the Consumer Advisory Board and Consumer Advocates

May 27, 2014

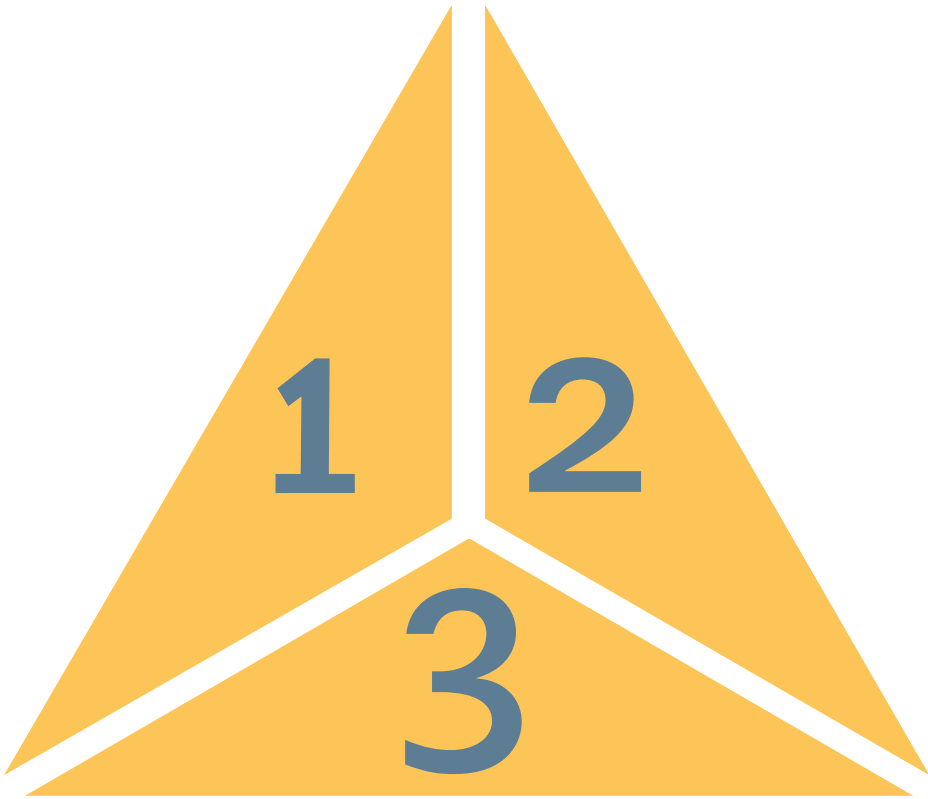
What is the State Innovation Model Initiative?

- The State Innovation Model Initiative (SIM) is an initiative of the Center for Medicare and Medicaid Innovation (CMMI)
- CMMI was created under the ACA to improve quality and contain costs
- *SIM Design* grants enable states to develop a State Healthcare Innovation Plan to improve health and healthcare
- Align providers, consumers, employers, payers, and state leaders around health and health care reforms
- Reach 80% of Connecticut's citizens in 3-5 years
- Connecticut's Healthcare Innovation Plan was submitted December 30, 2013

Connecticut's vision for reform…

Establish a whole-person-centered health care system that improves community health and eliminates health inequities; ensures superior access, quality, and care experience; empowers individuals to actively participate in their health and healthcare; and improves affordability by reducing healthcare costs.

Primary Drivers of Transformation

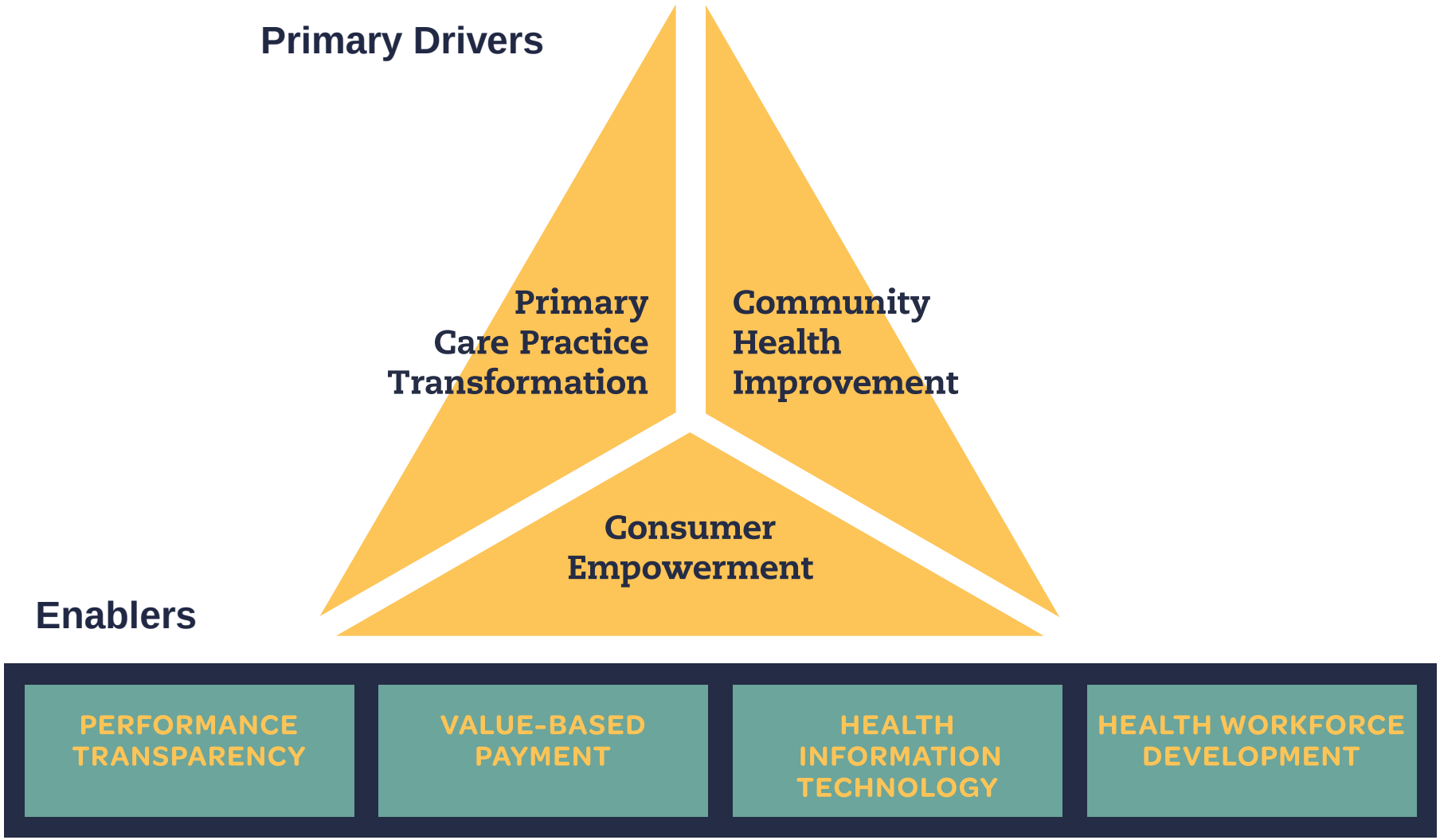


1. PRIMARY CARE TRANSFORMATION

2. COMMUNITY HEALTH IMPROVEMENT

3. CONSUMER EMPOWERMENT

Enabling Initiatives



1. Primary Care Transformation

- Primary care transformation to Advanced Medical Homes
- Practices joining together with enhanced capabilities & infrastructure
- Value-based payment tied to quality and care experience

Learning from health care stories

A CHILD WITH ASTHMA

Kathy is a six year old girl who came into the office for asthma. The exam doesn't consider important things about Kathy, such as her history of anxiety, violence in the home, and a parent with addiction problems. Her mother doesn't entirely understand the care plan, which contains many unfamiliar terms, and does not explain why and how conditions in the home might affect asthma. The PCP is also unaware of a longstanding infestation of mice. Kathy has a series of visits to the ED, ultimately leading to a hospitalization. The PCP learns of this several weeks after her discharge.

What Consumers Tell Us

- Coverage and care are unaffordable
- Long wait times (especially for specialists)
- Limited office hours
- Not enough time with PCP or specialist
- Not listened to or feel unwelcome
- PCP is too focused on Electronic Health Record
- No information or information is hard to understand
- Poor communication between PCPs, specialists and hospitals
- Discrimination against those with disabilities

What Doctors Tell Us

- Primary care is often administratively burdensome and unrewarding
  - Huge paperwork demands
  - Other administrative burdens like prior authorization
  - Not enough time with patients
  - EHRs get in the way of relationship with patient
- Poor or inefficient communication with other doctors and hospitals
- No one to help teach patients in self-care
- Needed services are often unavailable (e.g., behavioral health)
- No resources to connect

Connecticut's Advanced Medical Home Model

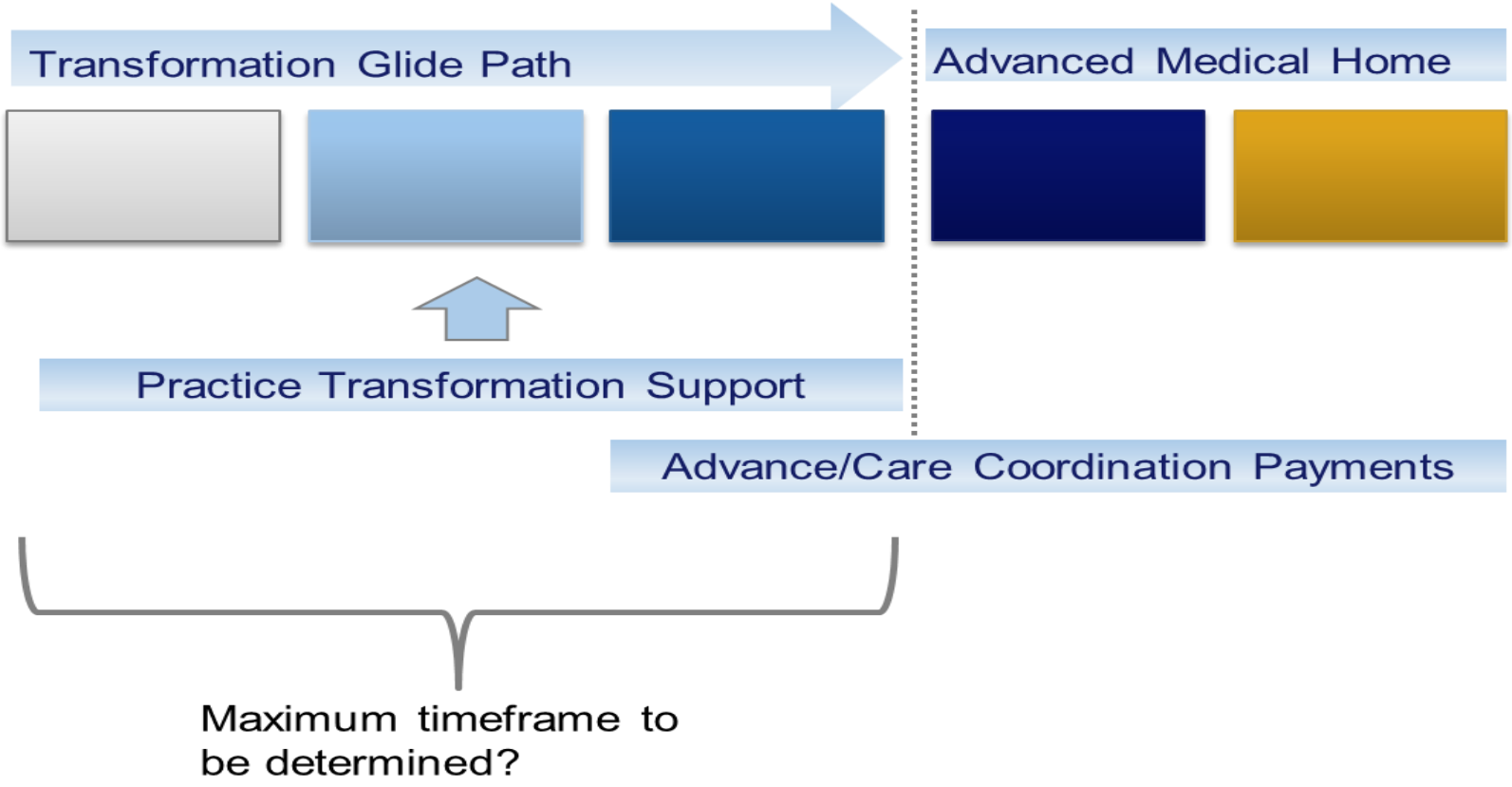
CORE ELEMENTS

- Whole-person centered care
- Enhanced access
- Population health management
- Team-based coordinated care
- Evidence-based informed clinical decision making

OUR ASPIRATIONS

- Better health for all
- Improved quality and consumer experience
- Promote health equity and eliminate health disparities
- Reduced costs and improved affordability

Advanced Medical Home: Glide Path



Helping Providers Achieve Recognition

- Practices vary greatly in their need for support to meet AMH standards
- For providers without a large group affiliation, we created the Glide Path Program
  - Facilitate the practice transformation process.
  - Provider participants receive support as they adopt advanced practices like whole-person-centered care and care coordination.
  - Accountable for meeting milestones and for achieving true practice transformation
- During Glide Path, providers that demonstrate readiness will qualify for advance payments to support care coordination and other functions

Team-Based Whole-Person Centered Care

HEALTH CARE STORY: KATHY

When Kathy comes into the primary care office for symptoms of asthma, her primary care physician partners with her and her family to manage and coordinate her care. A concern for the well-being of Kathy and her family is expressed in verbal and nonverbal interactions. Kathy and her mom feel listened to. She is given a whole-person assessment to identify her mental health issues, changes in her living situation, other health conditions, and other social-determinants of her health and underlying causes of her asthma.

A Care Coordinator provides information to Kathy and her family about asthma triggers, and makes referrals to a mental health provider for the parent's addiction problems, as well works with them to address housing concerns.

Team-Based Whole-Person Centered Care

HEALTH CARE STORY: KATHY

Together with the family, a comprehensive care plan is developed, with understandable language, to meet their goals; including setting a schedule for follow-up assessment phone calls and appointments. The Care Coordinator ensures that Kathy's family understands the care plan, as well as how conditions in the home might affect Kathy's asthma.

Immediately after the visit, the Care Coordinator arranges an introduction to the practice's licensed clinical social worker. Kathy returns to the practice for several behavioral health treatment visits. Her anxiety is related to bullying at school, which the social worker helps address with Kathy's educational team.

2. Community Health Improvement

- Regional communities set priorities for health improvement and health equity
- Collaborative solutions across care delivery, public health, schools, business and community organizations
- Prevention Service Centers
- Financial incentives tied to health improvement

Prevention Service Centers

- One-stop shopping for quality, evidence-based prevention services
- Formal affiliations with primary care practices and shared accountability for quality and outcomes
- Unique understanding of communities and populations served and able to delivery high quality, culturally and linguistically appropriate services
- Use community health workers

Prevention Service Centers - Core Services

- Asthma Home Environmental Assessments (putting on AIRS)
- Diabetes Prevention Program (DPP)
- Falls Prevention Program

Coordinated, community-based care

HEALTH CARE STORY: KATHY

The Care Coordinator connects Kathy and her family with a Prevention Service Center in their community which conducts a home assessment to identify asthma triggers that may be present. The home assessment reveals a mice infestation and actions are taken to address this important asthma trigger. Through direct messaging, there is timely information flow about Kathy's progress from the Prevention Services Center to her primary care provider.

3. Consumer Empowerment

- Transparent quality, consumer experience, and cost
- Shared decision making tools
- Insurance and employer incentives to reward good health behavior

Consumer Empowerment

- **Better consumer information, education and tools** to enable health, wellness, and illness self-management, including shared decision making with providers
- **Consumer input and advocacy** through involvement in the SIM governance structure and through consumer care experience surveys that directly affect provider payment
- **Consumer incentives** to encourage healthy lifestyles and effective illness self-management through value-based insurance designs (VBID) and employer incentive programs

Enabling Initiatives

- Performance Transparency
- Health Information Technology
- Value-Based Payment
- Workforce Development

Enabling Initiative – Performance Transparency

- **Create a common scorecard** that reflects the provider's ability to meet measures of health status, quality of care and consumer experience
- **Track primary care performance** for quality, care experience, equity and cost measures, with the goal of future expansion to other parts of the healthcare system
- **Combine data across payers** in order to be able to track a provider's true performance for their entire patient panel and to make reporting more efficient
- **Ensure multiple levels of reporting** so that consumers, payers, providers and policy makers can access quality, cost, price, and equity information

Enabling Initiative – Value-based payment

- **Pay-for-Performance**

  Financial rewards for meeting quality and care experience targets

  Available for Glide Path participants

  Teaching improvement - provides experience necessary for future success

  500+ attributed consumers

Enabling Initiative – Value-based payment

- **Shared Savings Program**

  Share in savings if meeting quality and care experience targets

  Payer and providers negotiate whether to share in losses

  Practices have met initial quality metrics and progressing AMH standards

  5,000+ attributed consumers

  Guiding principle - underservice disqualifies a practitioner from shared savings

Health information technology – Capabilities that support reforms

Category	
Payer analytics complemented by **provider analytics**	▪ Tools for payers to analyze claims to produce payment-related analytics, including metrics for outcome, quality and cost ▪ Complemented by provider analytics based on clinical data
Provider-payer-patient connectivity	▪ Channels (e.g., portal) for providers and patients to access and submit information, data and analytics required to support care delivery and payment models
Provider-patient care mgmt. tools	▪ Provider tools (e.g., workflow, event management, analytics) to coordinate the medical services for a patient
Provider-provider connectivity	▪ Integrated clinical data exchange among doctors, hospitals, and other health care providers through a secure, electronic network; Direct messaging and e-consult

Enabling Initiative – Workforce Development

- Better data on CT's health workforce
- Inter-professional education (IPE) for team based care
- A training program for Community Health Workers
- Preparing our current health workforce for new models of care delivery
- Innovation in and expansion of primary care residency programs
- Establishing better and more flexible career tracks for health professionals and allied health professionals

Coordinated, community-based care

HEALTH CARE STORY: KATHY

A Community Health Worker follows up with Kathy's mother about her substance use problem and violence in the home. She meets several times with her to makes sure that she is successfully connected to care and support.

Calls, texts, or emails are used as reminders for routine appointments. Kathy's mother uses the practice's consumer portal to ask questions about Kathy's medication. ED visits and hospital admissions are successfully avoided.

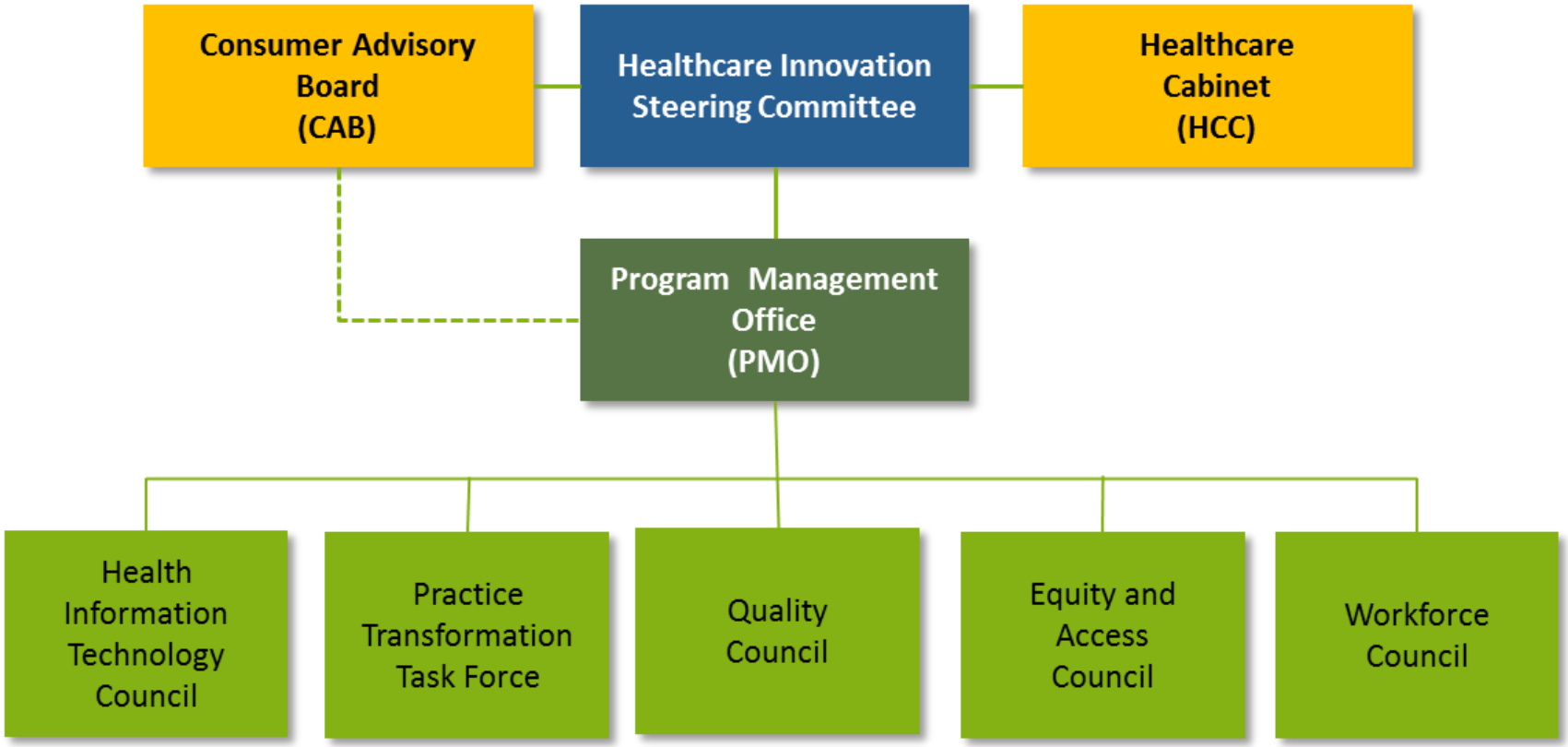
Improved access and enhanced health information

HEALTH CARE STORY: KATHY

Kathy's primary care provider is part of an Advanced Medical Home. The practice knows that it will be accountable for the care it provides, including the care experience for Kathy's mom and the effective control of Kathy's asthma.

The practice receives regular reports on quality, efficiency, and patient satisfaction. The practice uses this information to continuously improve the quality of service that they provide children like Kathy.

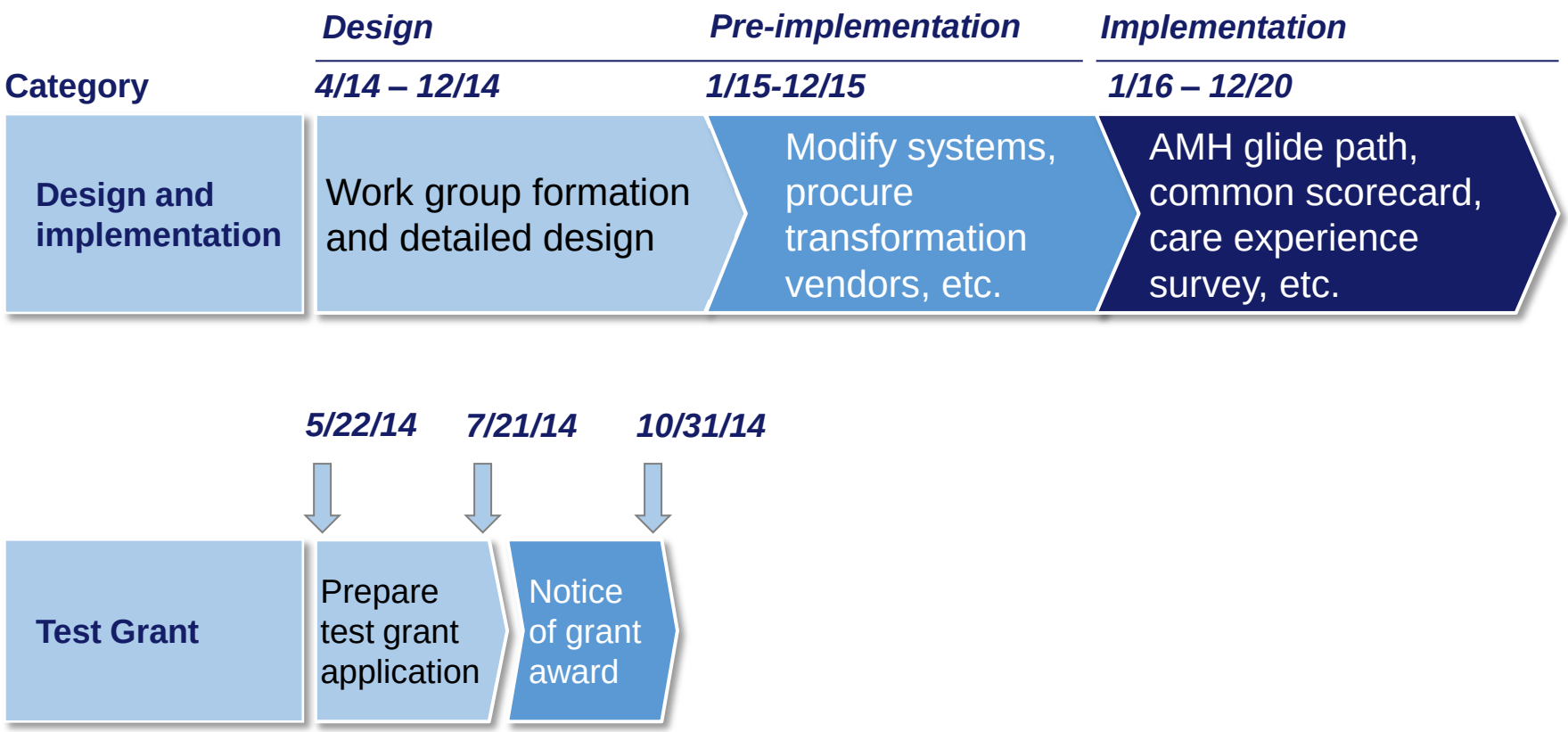
Governance


Consumer Advisory Board (CAB)
Healthcare Innovation Steering Committee
Healthcare Cabinet (HCC)
Program Management Office (PMO)
Health Information Technology Council
Practice Transformation Task Force
Quality Council
Equity and Access Council
Workforce Council

Next steps

- Apply for $20 to $100 million dollars to help implement and test our model
- Governor’s budget includes resources to start implementing our plan:
  - $3.2 million in Program Management Office within Office of Healthcare Advocate
  - $65,000 in the Office of the State Comptroller for a healthcare analyst

Timeframe


Design
Pre-implementation
Implementation
Category
4/14 – 12/14
1/15-12/15
1/16 – 12/20
Design and implementation
Work group formation and detailed design
Modify systems, procure transformation vendors, etc.
AMH glide path, common scorecard, care experience survey, etc.
5/22/14
7/21/14
10/31/14
Test Grant
Prepare test grant application
Notice of grant award

Managing the Transformation – Transformation Road Map

INNOVATION PLAN WILL BE IMPLEMENTED OVER FIVE YEARS, DIVIDED INTO FOUR PHASES:

- **Detailed Design (April to December, 2014)**

  Establish new governance structures and form a program management office (PMO), with a small dedicated staff

  PMO will develop the more detailed technical design necessary to support new models

- **Pre-implementation planning and activities (January 2015 to December 2015)**

  Pending the award of grant and other funding, initiate implementation planning targeted at a July 1, 2015 launch date for new multi-payer capabilities and processes

  Example activities include procurement of technology development, practice transformation, and other external products and services necessary to support launch

Managing the Transformation – Transformation Road Map

- **Wave 1 Implementation (January 2016 to December 2016)**

  First year of operations of multi-payer model for AMH as well as initiation of new capabilities to support Workforce Development

  Sample activities will include the capture of clinical data and transformation milestones through the multi-payer provider portal, quarterly payments of care coordination fees, and design of the Connecticut Service Track

- **Wave 2+ Scale-Up (January 2017 to December 2020)**

  Continuous improvement of the common scorecard, consumer/provider portal, data aggregation, and analytic and reporting capabilities

  Primary care providers continue to be enrolled in the Glide Path and AMH model; providers continue to transition from P4P to SSP as they achieve the necessary scale and capabilities over time

  Major expansion of Community Health Improvement and Workforce strategies, including establishment of Prevention Service Centers

For more information…

- Additional information about the SIM initiative – including the final Connecticut Healthcare Innovation Plan – can be found at: http://www.healthreform.ct.gov
- Click on “SIM Initiative”

*Please share your thoughts by emailing us at **sim@ct.gov**.*